ADHS HealthCheck Programs

Fit at Fifty HealthCheck Program

Client's Consent to Participate in the Program

The Fit at Fifty HealthCheck Program is a colorectal cancer screening program.

You can participate in the Fit at Fifty HealthCheck Program if:

- You are 50 years or older
- You do not have health insurance, your insurance does not cover the services offered by FFHP, or your co-pay for colorectal cancer screening is greater than $100
- You do not have Medicare Part B
- You do not qualify for AHCCCS (Arizona Health Care Cost Containment System)
- The total household income is within the limit set by ADHS (between 100%-250% of the Federal Poverty Level)
- You are determined to be clinically eligible by your provider

If you qualify, the Fit at Fifty HealthCheck Program pays for:

- Yearly fecal immunochemical test (FIT) to screen for colorectal cancer
- Colonoscopy and related services every 10 years or more often due to risks or findings on the initial colonoscopy
- Biopsy and polypectomy during colonoscopy
- Office visits related to tests above

The Fit at Fifty HealthCheck Program will <u>not</u> pay for:

- Any tests which may be needed if your health care provider finds other problems
- Treatment, if these tests find a problem. If you need colorectal cancer treatment, the Fit at Fifty HealthCheck Program will refer you to a location with low-cost treatment

I agree to participate in the Fit at Fifty HealthCheck Program. I understand that I have to do the following things:

- I will call my provider to schedule my yearly appointment
- If I cannot keep my appointment, I will call my provider to cancel
- I will keep all referral appointments for follow-up tests, as necessary. If I cannot keep my appointment, I will call my Fit at Fifty HealthCheck case manager.
- If I decide that I no longer want to participate in the Fit at Fifty HealthCheck Program, I will call my case manager
- Failure to comply with any of the above will result in disenrollment and that I may be responsible for charges

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Provider: _____ Phone: _____

Case Manager: _____ Phone: _____